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9	BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS	
10	STATE OF CALIFORNIA	
11	To the Metter of the Acquestion Against.	Case No. 2010-368
12		Case No.
13	RACHEL MARGARET SOMOGYI 13651 Tradition Street San Diego, CA 92128	ACCUSATION
14	Registered Nurse License No. 328204	
15	Public Health Nurse License No. 32192 Nurse Practitioner License No. 3129	
16	Nurse Practitioner Furnisher License No. 3129 Respondent.	
17	Complainant alleges:	
18	PARTIES	
19	1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her	
20	official capacity as the Interim Executive Officer of the Board of Registered Nursing, Departmen	
21	of Consumer Affairs.	
22	2. On or about March 31, 1981, the Board of Registered Nursing issued Registered	
23	Nurse License Number 328204 to Rachel Margaret Somogyi. The Registered Nurse License was	
24	in full force and effect at all times relevant to the charges brought herein and will expire on	
25	July 31, 2010, unless renewed.	
26	3. On or about November 20, 1981, the Board of Registered Nursing issued Public	
27	Health Nurse License Number 32192 to Rachel Margaret Somogyi. The Public Health Nurse	
40	II · · · · · ·	

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License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2010, unless renewed.

- 4. On or about September 6, 1986, the Board of Registered Nursing issued Nurse Practitioner License Number 3129 to Rachel Margaret Somogyi. The Nurse Practitioner License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2010, unless renewed.
- 5. On or about February 9, 1994, the Board of Registered Nursing issued Nurse Practitioner Furnisher License Number 3129 to Rachel Margaret Somogyi (Respondent). The Nurse Practitioner Furnisher License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2010, unless renewed.

JURISDICTION

- 6. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.
 - 7. Section 2750 of the Code states:

Every certificate holder or licensee, including licensees holding temporary licenses, or licenses placed in an inactive status, may be disciplined as provided in this article. As used in this article, "license" includes certificate or registration, or any other authorization to engage in practice regulated by this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

8. Section 2764 of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated. Section 2811 (b) provides that an expired license may be reinstated at anytime within eight (8) years of its expiration.

STATUTORY PROVISIONS

9. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- (a) Unprofessional conduct, which includes, but is not limited to, the following:
- (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

REGULATORY PROVISIONS

10. California Code of Regulations, title 16, section 1443, states:

As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

11. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

- (1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.
- (2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.
- (3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.
- (4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to

be delegated, and effectively supervises nursing care being given by subordinates.

- (5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.
- (6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

- Permanente Hospital in the Infectious Disease Department, Respondent began providing health care services to patient M.W. for management of his chronic disease, AIDS. Although Respondent usually treated M.W. during his routine follow-up visits related to his chronic illness, in June 1998, M.W. was seen by Dr. B.. M.W. complained to Dr. B. of a sore throat. Dr. B. documented in M.W.'s medical records his observation of a 1cm left supraclavicular lymph node and noted that it could be a reactive node relating to M.W.'s AIDS. Dr. B. did not prescribe any specific treatment regarding the node. M.W. was instructed to return for a follow-up appointment in three months.
- 14. In October 1998, and again in March 1999, M.W. was seen by Respondent for his scheduled follow-up appointments. Respondent did not document in M.W.'s medical records anything regarding the node observed in June 1998 by Dr. B., or whether M.W. was still

experiencing the sore throat that he had complained about to Dr. B.. Respondent did not conduct or document a physical exam of M.W. during the follow-up appointments.

- 15. In June 1999, M.W. was seen by Respondent who documented that M.W. complained of a sore throat. Respondent diagnosed M.W. with sinusitis, obtained a throat culture, and prescribed antibiotics. Respondent did not document lymphadenopathy during M.W.'s June 1999 appointment. Respondent advised M.W. to contact her if his sore throat did not get better with the prescribed antibiotics. Respondent instructed M.W. to return in three months for a follow up appointment.
- 16. M.W. was seen by Respondent for his follow up exams in November 1999, April 2000, and October 2000, during which Respondent did not inquire about or document any information regarding M.W.'s sore throat, if any, or whether M.W.'s lymph node was still swollen. Respondent did not conduct or document a physical exam of M.W. during any of these appointments, except for a skin-check completed in October 2000.
- 17. In March 2000, M.W. was seen by Respondent and complained of a sore back.

 Respondent did not complete or document a physical exam during the appointment.
- 18. In April 2001, M.W. was seen by Respondent and complained of a bad taste in his mouth. Respondent did not complete or document a physical exam during the appointment.
- 19. In October 2001, M.W. was seen by Dr. B. who documented a 1 cm left node in a different spot from the lymph node spot previously documented in 1998. Dr. B. did not order any new tests and instructed M.W. to return for a follow-up appointment in three-to-four months.
- 20. In April 2002, M.W. was seen by Respondent who documented that M.W. complained of allergy symptoms. Respondent did not complete or document a physical exam during the appointment. Respondent did not document any inquiry or information regarding the node documented by Dr. B. in October 2001.
- 21. In October 2002, M.W. was seen by Respondent who did not conduct or document a physical exam of M.W. during the appointment. Respondent did not document any inquiry or information regarding the left node documented by Dr. B. in October 2001.

- 22. On April 2, 2003, M.W. was seen by Respondent who documented that M.W. complained of sinusitis. Respondent documented that M.W. denied having a sore throat. Respondent documented that M.W. had enlarged submandibular lymph nodes, prescribed antibiotics, and ordered a chest x-ray.
- 23. M.W. had a chest x-ray on April 23, 2003 which showed an increased density of the T6 vertebral body. The radiologist documented in M.W.'s medical chart that more views were necessary. On May 30, 2003, more chest x-ray views were taken of M.W. which showed T6 vertebral body sclerosis. The radiologist recommended a bone scan for M.W.
- 24. In December 2003, M.W. was seen by Respondent who did not complete or document a physical exam of M.W. Respondent ordered M.W. to repeat the same chest x-rays that were completed in Spring 2003. Respondent did not document any follow-up treatment or inquiry regarding the bone scan that was recommended by the radiologist in Spring 2003. Respondent instructed M.W. to schedule a follow up appointment in three months.
- 25. In December 2003, the chest x-rays ordered by respondent were taken. The radiologist documented that M.W.'s x-rays showed sclerosis to the T6 vertebral body and also to the T11 vertebral body, which had not been observed on the May 2003 x-rays. The radiologist recommended a bone scan for M.W.
- 26. On or about January 4, 2004, M.W. telephoned Dr. B. regarding the results from his chest x-rays taken in December 2003. Dr. B. was not available and M.W. left a message requesting a return call. Neither Dr. B. nor Respondent returned M.W.'s telephone call inquiry. On or about February 6, 2004, M.W. called again to inquire about the December 2003 x-ray results and a bone scan was scheduled for February 8, 2003.
- 27. On February 8, 2003, a bone scan was conducted on M.W. The bone scan showed subtle uptake in T11 and T8, which could not rule out unusual chronic infection or lytic measures.
- 28. On February 12, 2004, M.W. was seen by his primary care physician who told M.W. that his bone scan results were normal.

- 29. On April 20, 2004, M.W. was seen by Respondent. M.W. told Respondent that his primary care physician stated the bone scan results were normal. Respondent did not palpate any nodes during M.W.'s appointment. M.W. was instructed to schedule a follow-up in three months.
- 30. In July 2004, M.W. was seen by Respondent who documented that M.W. complained of a lump on his neck. Respondent conducted a physical exam and documented a mass and lymphadenopathy. Respondent consulted with Dr. B. and documented that they discussed M.W.'s x-ray and bone scan results. M.W. was referred to a head and neck surgeon for a biopsy.
- 31. In or about July 2004, the neck mass was removed from M.W.'s neck and confirmed that M.W. had thyroid cancer which had metastases. M.W. was told his cancer was terminal as there is no curative therapy, effective chemotherapy, or radiation treatment available for the thyroid cancer that had metastases.
- 32. M.W. made a consumer complaint to the Board of Registered Nursing regarding Respondent. M.W. stated that he complained many times of a sore throat during his appointments with Respondent. However, Respondent did not document any such complaints in M.W.'s medical chart or records.

CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Incompetence)

- 33. Respondent is subject to disciplinary action under Business and Professions Code section 2761, subsection (a) (1) for incompetence in her care of patient M.W. during frequent scheduled visits relating to his chronic illness, as described in paragraphs 13 through 32, above, which are incorporated herein by reference. Respondent's incompetence was demonstrated as follows:
- a. Between the dates of October 1998 and July 2004, Respondent failed to fully evaluate patient M.W., failed to conduct a physical exam of M.W., and/or failed to thoroughly document her observations regarding her exam of M.W. when M.W. presented for his routine follow-up visits.
- b. Between the dates of October 1998 and July 2004, Respondent failed to perform appropriate follow-up on abnormal findings noted during physical examinations of M.W. at prior